112

112 Telemedicine Services

This general information is related to the telehealth medical services rendered by Alabama Medicaid (Medicaid) providers. Providers are expected to comply with Alabama's Telehealth Medical Services law (Code of Alabama, Sections 34-24-701 through 34-24-707) at all times.

112.1 Enrollment

Alabama Medicaid's fiscal agent enrolls providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Federal requirements mandate providers re-validate periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-validate. Failure to re-validate and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-validate, providers will have to submit a new application for enrollment.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as an enrolled provider is added to the Alabama Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements.

NOTE:
The 10-digit NPI is required when filing a claim.

Providers must submit the Telemedicine Service Agreement/Certification to Medicaid's fiscal agent. The form is located on the Medicaid website at: www.medicaid.alabama.gov. Once the form is received, providers will be enrolled with Medicaid with a specialty type of 931 (Telemedicine Service). Providers must have the specialty type of 931 to bill for telemedicine services.

Provider Types Eligible for Reimbursement for Telemedicine Services

- Physicians
- Certified Registered Nurse Practitioners (CRNPs)

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

- Physician Assistants
- Rehabilitative Option Providers
- Psychologists
- Licensed Professional Counselors
- Associate Licensed Counselors
- Licensed Marriage and Family Therapist and Associates
- Licensed Master Social Workers
- Licensed Independent Clinical Social Workers
- Licensed Psychological Technicians
- Speech Therapists
- Optometrists
- Applied Behavior Analysts
- Early Intervention
- Children's Rehabilitation Service
- Pharmacists/Pharmacies
- Targeted Case Management

Provider Types Not Eligible for Reimbursement for Telemedicine Services

- Physical Therapists
- Occupational Therapists
- DME suppliers
- Ambulance providers
- Chiropractors
- Home Infusion
- Laboratory

General Enrollment Policy for Telemedicine Services Providers

Refer to the respective Alabama Medicaid Provider Billing Manual chapter that describes the service rendered by providers listed above for general enrollment information.

112.2 Benefits and Limitations

This section describes telemedicine provider requirements. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Definitions

As found in Alabama law the following definitions apply to Medicaid's telemedicine policy:

Telehealth medical services means "digital health, telehealth, telemedicine, and the applicable technologies and devices used in the delivery of telehealth.

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

The term does not include incidental communications between a patient and a physician.

- Digital Health is defined as “the delivery of health care services, patient education communications, or public health information via software applications, consumer devices, or other digital media.”
- Telehealth is defined as “the use of electronic and telecommunications technologies, including devices used for digital health, asynchronous and synchronous communications, or other methods, to support a range of medical care and public health services.”
- Telemedicine is defined as “a form of telehealth referring to the provision of medical services by a physician at a distant site to a patient at an originating site via asynchronous or synchronous communications, or other devices that may adequately facilitate and support the appropriate delivery of care. The term includes digital health but does not include incidental communications between a patient and a physician.”

The term irregular or infrequent services refers to “telehealth medical services” occurring less than 10 days in a calendar year or involving fewer than 10 patients in a calendar year.

Synchronous is defined as “the real-time exchange of medical information or provision of care between a patient and a physician via audio/visual technologies, audio-only technologies, or other means.”

Telemedicine Provider Requirements

Providers must identify themselves to the recipient with their credentials and name at the time of service.

Providers must obtain prior written or verbal consent from the recipient before services are rendered.

Telemedicine services may only be provided as a result of a patient’s request, part of an expected follow up, or a referral from the patient’s licensed physician with whom the patient has an established patient-physician relationship.

Services rendered via telecommunication system must be provided by a provider who is licensed, registered, or otherwise authorized to engage in his or her healthcare profession in the state where the patient is located. Per Alabama law, the provision of telemedicine medical services is deemed to occur at the patient’s originating site within this state.

Services must be within the provider’s scope of license.

Services must be provided to a recipient that is an established patient of the provider or practice or due to a referral made by a patient’s licensed physician with whom the patient has an established physician-patient relationship, in the usual course of treatment of the patient’s existing health condition.

Telemedicine services provided to minors under the age of medical consent must have a parent or legal guardian attend the telemedicine visit.

Only the provider rendering the services via telemedicine may submit for reimbursement for services.

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

Providers must indicate an in-state or qualifying bordering state site of practice address from which telemedicine services will be provided.

NOTE:

This policy does not expand or grant any authority outside that authority granted to the provider by their respective licensure board or by federal or state law.

Delivery Requirements of Telemedicine Services

Services must be administered via an interactive audio or audio and video telecommunications system which permits two-way communication between the distant site provider and the site where the recipient is located (this does not include electronic mail message or facsimile transmission between the provider and recipient).

Telemedicine health care providers shall ensure that the telecommunication technology and equipment used is sufficient to allow the health care provider to appropriately evaluate, diagnose, and/or treat the recipient for services billed to Medicaid and is HIPAA compliant.

Transmissions must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the transmission information. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver.

The provider shall implement confidentiality protocols that include, but are not limited to:

a. specifying the individuals who have access to electronic records;

b. usage of unique passwords or identifiers for each employee or other person with access to the client records;

c. ensuring a system to prevent unauthorized access, particularly via the internet; and

d. ensuring a system to routinely track and permanently record access to such electronic medical information.

These protocols and guidelines must be available for inspection at the telemedicine site and to Medicaid upon request.

NOTE:

A covered telemedicine service will count towards each recipient's benefit limit of 14 annual physician office visits.

Documentation of Services Delivered via Telemedicine

Providers shall document in the medical record detailed information of the telemedicine visits including, but not limited to:

- Identification of the patient.

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

- Identification of parent or legal guardian attending the telemedicine visit if recipient is under the age of medical consent.
- Physical location of the patient, including the city and state.
- The medical record documentation must accurately reflect the services rendered and the level of medical decision making to substantiate the procedure code billed.
- The same “in” and “out” documentation is required for telemedicine as is required for current services with incremental timeframes provided in person.
- Identification of the provider including credentials.
- Patient’s consent for the use of telemedicine delivery of health care services. This consent must be documented in the recipient’s medical record.
- Condition for which the care is being provided.
- Medical necessity and appropriateness of services billed.
- Follow up care needed.
- Other relevant details of the visit, to include BMI recording, when applicable.

Origination Sites

The following are required for the origination site where the patient is located:

- The site provider shall ensure that the telecommunication technology and equipment used at the origination site is HIPAA compliant and is sufficient to allow the appropriate evaluation, diagnosis, and/or treatment of the patient.
- The site provider shall implement protocols that ensure the same confidentiality of the telemedicine visit as for in-person visits.
- Regardless of the location of the recipient, it is the provider’s responsibility to ensure the telemedicine visit meets all required HIPAA rules and regulations regarding telemedicine visits.
- The following sites are recognized by Medicaid as origination sites:
  - Physician and practitioner offices
  - Rural Health Clinics (RHCs)
  - Federally Qualified Health Centers (FQHCs)
  - Skilled Nursing Facilities (SNFs)
  - Community Mental Health Centers (CMHCs)
  - Renal Dialysis Facilities
  - Mobile Stroke Units
  - Alabama Department of Public Health

Telemedicine services can be rendered to a recipient in their home. However, a recipient’s home should not be considered an origination site entitled to receive an origination site fee.

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

NOTE:

If a Medicaid-enrolled provider performs another medically necessary service(s), the provider may bill for the covered service(s) in addition to providing his/her facility as an origination site and be eligible for reimbursement for the origination site facility fee and the other medically necessary service(s).

Prescribing of Medications and Controlled Substances via Telemedicine

In accordance with Alabama's Telemedicine Law, an enrolled provider may prescribe a legend drug, medical supplies, or a controlled substance via telemedicine if the prescriber is authorized to do so under state and federal law. However, a prescription for a controlled substance may only be issued via telemedicine if:

- The telemedicine visit includes synchronous audio or audio-visual communication using HIPAA compliant equipment with the prescriber;
- The prescriber has had at least one in-person encounter with the patient within the preceding 12 months; and
- The prescriber has established a legitimate medical purpose for issuing the prescription within the preceding 12 months.

BMI Requirements

The BMI will be required for office visits including the telemedicine visits. The BMI is required at least once per calendar year on all claims with procedure codes 99202-99205, 99211- 99215, and 99242-99245 and EPSDT procedure codes 99382-99385 and 99392-99395. Providers should use subjective data to calculate the BMI which can include providers asking the recipient for his or her height and weight during the telemedicine visit. The BMI should be calculated, based on the information provided by the recipient, and appended to the claim for reimbursement. The BMI should also be documented in the recipient's medical record.

Remote Patient Monitoring

For information related to Remote Patient Monitoring, please refer to Chapter 111 - Remote Patient Monitoring (RPM) of the Provider Billing Manual.

112.3 Prior Authorization and Referral Requirements

Prior authorization is not required for services to be delivered via telemedicine, though prior authorization may be required for the individual procedure codes billed. Refer to the Provider Billing Manual chapter that describes the service provided for prior authorization requirements.

Refer to Appendix A and the respective Alabama Medicaid Provider Billing Manual chapter that describes the service provided for information about Early and Periodic Screening, Diagnostic, and Testing (EPSDT) referrals.

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

112.4 Cost Sharing (Copayment)

The copayment amount for office visit* including crossovers is:

$3.90 for procedure codes reimbursed $50.01 and greater
$2.60 for procedure codes reimbursed between $25.01 and $50.00
$1.30 for procedure codes reimbursed between $10.01 and $25.00

* The following CPT codes are considered office visits and the copayment is based on Medicaid's allowed amount (fee schedule) for each procedure:

99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245

Copayment does not apply to services provided for pregnant women, nursing home residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

112.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

Refer to the respective Alabama Medicaid Provider Billing Manual chapter that describes the service provided for general information on completing the appropriate claim form.

This section describes telemedicine services information. Providers should refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

112.5.1 Time Limit for Filing Claims

Medicaid requires all claims for providers to be filed within one year of the date of service. Refer to Chapter 5 for more information regarding timely filing limits and exceptions.

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

112.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885 or 1-800-621-8335.

Refer to the respective Alabama Medicaid Provider Billing Manual chapter that describes the service provided by providers listed in Section 112.1 for general information for billing appropriate diagnosis codes with procedure codes and modifiers listed in Section 112.5.3.

112.5.3 Procedure Codes and Modifiers

Procedure Codes

Procedure codes listed below are reimbursable services when delivered via telemedicine by a provider type listed in Section 112.1. The procedure codes (and applicable modifiers) are listed below by provider type or services. For further detailed information, refer to the below referenced chapters of the Provider Billing Manual.

Eye Care – Chapter 15

- Office visit codes for established patients: CPT 99211-99215

CRNPs/PAs Services– Chapter 21

- Office or other outpatient visits for recipients ages 21 and older: CPT 99202-99205, 99211-99215
- **Office or other outpatient visits for recipients ages 0-20 billed as an EPSDT referred service: CPT 99211-99215
- **EPSDT interperiodic screenings for recipients ages 0-20: CPT 99211-EP-99215-EP
- Initial hospital inpatient or observation care: CPT 99221-99223
- Subsequent hospital inpatient or observation care: CPT 99231-99233
- Hospital inpatient or observation care: CPT 99234-99236
- Hospital inpatient or observation discharge day management: CPT 99238-99239
- Office or other outpatient consultation: CPT 99242-99245
- Inpatient or observation consultation: CPT 99252-99255
- Psychiatric diagnostic testing: CPT 90791
- Psychiatric diagnostic testing with medical services: CPT 90792

***Refer to Appendix A – Well Child Visit (EPSDT) for information on billing. Claims not billed for telemedicine services in compliance with policy may be subject to recoupment.*

Physician Services – Chapter 28

- Office or other outpatient visits for recipients ages 21 and older: CPT 99202-99205, 99211-99215
- **Office or other outpatient visits for recipients ages 0-20 billed as an EPSDT referred service: CPT 99211-99215
- **EPSDT interperiodic screenings for recipients ages 0-20: CPT 99211-EP – 99215-EP
- Initial hospital inpatient or observation care: CPT 99221-99223

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

- Subsequent hospital inpatient or observation care: CPT 99231-99233
- Hospital inpatient or observation care: CPT 99234-99236
- Hospital inpatient or observation discharge day management: CPT 99238-99239
- Office or other outpatient consultation: CPT 99242-99245
- Inpatient or observation consultation: CPT 99252-99255
- Psychiatric diagnostic testing: CPT 90791
- Psychiatric diagnostic testing with medical services: CPT 90792

***Refer to Appendix A – Well Child Visit (EPSDT) for information on billing. Claims not billed for telemedicine services in compliance with policy may be subject to recoupment.*

Behavioral Health – Chapter 34

- Psychotherapy:
  - *90832, 90834, 90837, 90846, 90847 and
  - *H2011 [psychologist only]

*** denotes service must be done with both audio and visual (GT modifier)**

Applied Behavioral Analysis Therapy – Chapter 37

Deleted: ~~Behavior Identification Assessment…Treatment: HCPCS 0373T~~

- Adaptive Behavior Modification: CPT 97155
- Family Adaptive Behavior Treatment Guidance: CPT 97156
- Multiple Family, Group Treatment Guidance: CPT 97157

Speech Therapy – Chapter 37

- Treatment of speech: 92507, 92508
- Evaluation of speech sound production: CPT 92523

Children's Rehabilitation Service – Chapter 100

- Office visits: 99202-HT, 99203-HT, 99204-HT, 99205-HT, 99212-HT, 99213-HT, 99214-HT, 99215-HT

Rehabilitative Option Services– Chapter 105

- *Psychiatric evaluation: 90791
- *Psychotherapy: 90832, 90834, 90837, 90846, 90847, 90853, 90849
- *Psychological testing: 96130, 96131, 96136, 96137, 96138, 96139, 96146
- *Assessments: H0002, H0004, H0031-HF
- *Medication Monitoring: H0034
- *Peer support services: H0038 (with appropriate modifiers)
- *Crisis intervention: H2011
- *Treatment plan review: H0032
- Mental health care coordination: H0046
- Assertive Community Treatment (ACT) H0040-HE (Psychiatrist only)
- *Behavioral Health Placement Assessment H0002-HE
- *Psychoeducational Services H2027- HE
- *Nursing Assessment and Care T1001
- *Nursing Assessment and Care T1002
- *Nursing Assessment and Care T1003
- *Therapeutic Mentoring H2019

***denotes service must be done with both audio and visual (GT modifier)**

Targeted Case Management – Chapter 106

- Group 2: G9008-U2

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

- ^Group 3: G9005-U3,
- *Group 3: G9002-UA
- *Group 10: G9003-UA

***denotes service must be done with both audio and visual (GT modifier)**

Early Intervention – Chapter 108

- Intake Evaluation: T1023
- Audiology: 92550-TL, 92552-TL, 92553-TL, 92555-TL, 92556-TL, 92557-TL, 92567-TL, 92568-TL, 92579-TL, 92582-TL, 92583-TL, 92587-TL
- Family Support: H2027-TL
- Psychological Testing: 96112-TL
- Speech-Language Pathology: 92507-TL, 92508-TL, 97532-TL
- Vision Services: 99173-TL
- Treatment Plan Review: H0032-TL

Rehabilitative Services (ASD)- Chapter 110

- *Behavior Support H2019
- *In-Home Therapy T1027
- *Mental Health Care Coordination H0046
- *Peer Support Youth H0038- HA
- *Peer Support Family H0038-HC
- *Psychoeducational Services H2027
- Therapeutic Mentoring H2014

***denotes service must be done with both audio and visual (GT modifier)**

Modifiers

Providers meeting the telemedicine provider requirements listed above must append one of the following modifiers indicating the mode of telemedicine service delivery:

- GT for covered telemedicine services delivered via audio and visual telecommunications.
- FQ for covered telemedicine services delivered via audio only telecommunications.

Additional modifiers may be required. Refer to the chapter of the Provider Billing Manual that describes services provided for further information.

Reimbursement for services provided via telemedicine, audio only and audio and video telecommunications, will be paid at parity to those services provided face-to-face. Medicaid will continue to monitor and reevaluate, if deemed necessary.

Billing the Telemedicine Origination Site Facility Fee

Effective April 1, 2020, Medicaid pays an origination site facility fee of $20.00. The origination fee will be limited to one per date of service per recipient and may be billed by all of the providers listed above under Origination Sites (Section 112.2).

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

No origination site facility fee will be paid for an origination site not listed above. To receive the origination site facility fee, the following must be included on a CMS-1500 claim:

	Procedure Code
Providers	Q3014
Federally Qualified Health Centers and Rural Health Clinics	Q3014 (independent of the encounter rate)

NOTE:

If a Medicaid-enrolled provider performs another medically necessary service(s), the provider may bill for the covered service(s) in addition to providing his/her facility as an origination site and be eligible for reimbursement for the origination site facility fee and the other medically necessary service(s).

A recipient's home should not be considered an origination site entitled to receive an origination site fee.

Services not Eligible for Reimbursement for Telemedicine Services

Common examples of services via telemedicine not considered for reimbursement (not exhaustive):

- Chart reviews
- Electronic mail messages (between providers and recipients)
- Facsimile transmissions (between providers and recipients)
- Consultation between two providers
- Internet based communications that are not HIPAA-compliant or secure
- Services not directly provided by an enrolled provider or by office staff
- Services not normally charged for during an office visit
- Services not specifically listed in Provider Billing Manual chapters
- Communication that is not secure or HIPAA-compliant (e.g., Skype, FaceTime)

Exceptions may be made to the lists for providers and services not reimbursable under this policy in the event of a public health emergency, however, separate guidance would be issued in those instances.

NOTE:

If a Medicaid-enrolled provider performs another medically necessary service(s), the provider may bill for the covered service(s) in addition to providing his/her facility as an origination site and be eligible for

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

reimbursement for the origination site facility fee and the other medically necessary service(s).

112.5.4 Place of Service Codes

Refer to the respective Alabama Medicaid Provider Billing Manual chapter that describes the service provided for general information on completing the appropriate claim form.

112.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims with Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Chapter 5 Required Attachments, for more information on attachments.

112.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.